BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOHN CHARLES POH, JR., 2630 22nd Avenue San Francisco, CA 94116 Registered Nurse License No. 451774 Nurse Practitioner Certificate No. 8355 Nurse Practitioner Furnishing Certificate No. 8355 Respondent	Case No. 2008-217 OAH No. 2008020323

DECISION AFTER RECONSIDERATION

This matter came on regularly for hearing before Mary-Margaret Anderson, Administrative Law Judge of the Office of Administrative Hearings, at Oakland, California, on May 8 and 12, 2008. Complainant was represented by Kim M. Settles, Deputy Attorney General. Respondent was present and represented by Warren R. Webster, Attorney at Law.

The Administrative Law Judge issued her Proposed Decision on July 16, 2008. The Proposed Decision of the Administrative Law Judge was adopted by the Board of Registered Nursing on September 24, 2008, to become effective on October 24, 2008. Complainant petitioned for reconsideration of said Proposed Decision on October 17, 2008. On October 23, 2008, the Board issued an Order Granting a Stay of Execution for 10 days for the purpose of considering the petition. On October 31, 2008, the Board issued an Order Granting

Reconsideration of the Decision and further staying of the Decision until another Decision is rendered. The Board issued an Order Fixing Date For Submission of Written Argument on or before December 30, 2008. The respondent and complainant submitted written briefs.

Having reviewed the record including the petition for reconsideration, and respondent's opposition to the motion for reconsideration, and good cause appearing, the Board now makes and enters its Decision After Reconsideration as follows:

ORDER

The Board of Registered Nursing hereby issues the attached Proposed Decision dated June 12, 2009, as its final Decision in this matter.

This Decision shall become effective on July 13, 2009.

IT IS SO ORDERED this 15th day of June 2009.

Susanne Phillips, MSN, RN, FNP-BC
President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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In the Matter of the Accusation Against:	
JOHN CHARLES POH, JR.,	Case No. 2008-217
Registered Nurse License No. 451774, Nurse Practitioner Certificate No. 8355, Nurse Practitioner Furnishing Certificate No. 8355,	OAH No. 2008020323
Respondent.	

DECISION AFTER RECONSIDERATION

PROCEDURAL BACKGROUND

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter in Oakland, California, on May 8 and 12, 2008. Kim M. Settles, Deputy Attorney General, represented Complainant Ruth Ann Terry, M.P.H., R.N., Executive Officer of the Board of Registered Nursing (Complainant). Warren W. Webster, Attorney at Law, represented Respondent John Charles Poh, Jr. (Respondent). The record closed on May 12, 2008. The Administrative Law Judge issued her proposed decision on July 16, 2008, which dismissed the accusation. After due consideration, the Board of Registered Nursing (Board) adopted the proposed decision as its decision in this matter on September 24, 2008, with an effective date of October 24, 2008.

On or about October 17, 2008, Complainant petitioned pursuant to Government Code section 11521 for reconsideration of the decision and requested a stay of the decision not to exceed ten days pending evaluation of the petition for reconsideration. An order granting a stay of the decision was issued on October 23, 2008, to permit evaluation of the petition for reconsideration. After a preliminary opposition was filed by Respondent dated October 28, 2008, an order granting reconsideration was issued on or about October 31, 2008, indicated written argument could be filed upon receipt of the transcript and notice to the parties.

On or about December 1, 2008, Respondent filed a Motion to Vacate Order Granting Complainant's Petition for Reconsideration, arguing that the Board had not acted on the decision within 100 days as required by law, and that the Proposed Decision should be adopted by operation of law.

The transcript was ordered, and the parties filed additional briefs as permitted by the Board's Order Fixing Date for Submission of Arguments issued on or about November 25, 2008. The time for briefing having expired, the Board considered this matter on or about February 19, 2009. The entire record, including the transcript of the hearing, having been read and considered, pursuant to Government Code section 11521, the Board hereby makes the following decision and orders.

Motion To Dismiss Order Granting Reconsideration

Respondent argues that the Board's order granting the stay of the effective date of the proposed decision, and granting reconsideration of the proposed decision must be vacated. He states that the Board must act on the Proposed Decision within 100 days of the receipt of that decision, pursuant to Government Code section 11517, and that the October 24, 2008, was the 100th day permitted by law for the effective date of the decision. By issuing a stay on October 17 , 2008, of the effective date of that decision, the Board failed to act within the mandated 100 days, resulting in the decision being adopted by operation of law. (Gov. Code § 11517(c)(2).)

Respondent is correct in that the Board must act on a proposed decision within 100 days of receipt. (Gov. Code § 11517(c)(2).) The Board, however, timely exercised its duty on September 24, 2008, when it **adopted** the decision. (Gov. Code § 11517(c)(2)(A).) Respondent incorrectly argues that the decision must become effective within that time period, and uses the sheer coincidence of the effective date of the decision being the 100th date after receipt to bolster the argument.

The Board retained jurisdiction to order reconsideration. "The power to order a reconsideration shall expire 30 days after the delivery or mailing of a decision to a respondent, or on the date set by the agency itself as the effective date of the decision if that date occurs prior to the expiration of the 30-day period .... If additional time is needed to evaluate a petition for reconsideration filed prior to the expiration of any of the applicable periods, an agency may grant a stay of that expiration for no more than 10 days, solely for the purpose of considering the petition." (Gov. Code § 11521(a).) Complainant filed a Petition for Reconsideration on or about October 17, 2008, prior to the October 24, 2008, effective date. A timely stay of the effective date not to exceed 10 days was issued for the purpose of evaluating the already-filed petition, and the board ordered reconsideration within that additional 10-day period. (See, also, *Bonnell v. Medical Bd. of California* (2003) 31 Cal.4th 1255.) There is no requirement that the Board's decision following reconsideration be issued within the 100-day period outlined in Government Code section 11517(c)(2), and Respondent cites to none. Accordingly, the Board timely adopted the Proposed Decision, and timely issued a stay of an appropriate length prior to the effective date of that decision, thus retaining jurisdiction to act upon the Petition for Reconsideration. The Board thereafter timely ordered reconsideration of its decision. The Board's Order Granting Reconsideration need not be vacated, and Proposed Decision is not adopted by operation of law. The Board retains jurisdiction to act upon the merits of Complainant's Petition for Reconsideration.

FACTUAL FINDINGS

1. Complainant Ruth Ann Terry, M.P.H., R.N., filed the Accusation in her official capacity as Executive Officer, Board of Registered Nursing (Board), Department of Consumer Affairs.

2. The Board issued registered nurse license number 451774 to John Charles Poh, Jr. (Respondent) on March 31, 1990. The Board issued nurse practitioner certificate number 8355 to Respondent on June 26, 1996. The Board issued nurse practitioner furnishing certificate number 8355 to Respondent on January 29, 1998. The license and certificates are currently renewed until December 31, 2009.

3. The Accusation alleges cause for discipline of Respondent's nursing license and certificates based upon his care of inmate patient E. M.[1] on June 24 through July 1, 2005.[2]

4. The standard of proof employed in making the factual findings is clear and convincing evidence to a reasonable certainty.

5. Respondent is employed by the City and County of San Francisco as a nurse practitioner. He works at the San Francisco County Jail, where he provides nursing services to inmates.

6. In the San Francisco County Jail, nurses are the gatekeepers for medical care. Upon admission, inmates see a nurse and their need for care is assessed. If there is a need they are referred to a doctor or a nurse practitioner. Once housed in the jail an inmate can ask to see a nurse or a deputy can request that a nurse see a patient.

7. The Administrative Law Judge found that Respondent testified at the hearing in a forthcoming, straightforward, and credible manner.[3] His descriptions of the care he provided E. M. were consistent in the most important respects with the medical records and with statements attributed to him by the Board's investigator.

Patient E. M.

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[1] Initials are used to protect patient privacy.

[2] All dates are in 2005 unless another year is identified.

[3] Government Code section 11425.50(b) states, in pertinent part, "If the factual basis for the decision includes a determination based substantially on the credibility of a witness, the statement shall identify any specific evidence of the observed demeanor, manner, or attitude of the witness that supports the determination, and on judicial review the court shall give great weight to the determination to the extent the determination identifies the observed demeanor, manner, or attitude of the witness that supports it." This finding of credibility does not contain any observations of demeanor or attitude of Respondent.

8. E. M., born September 5, 1960, had medical conditions that included a history of high blood pressure and congestive heart failure. On June 19 jail medical staff conducted an intake screening. The following medications were ordered continued: atenolol, lisinopril, furosemide (Lasix), chewable baby aspirin and potassium chloride. A chart review was scheduled for June 21 and conducted by a nurse practitioner.

On June 23 Respondent saw E. M. in the jail clinic, examined him, took a history, and made appropriate minor adjustments to E. M.'s medications. At the time, no acute problems were evident except elevated blood pressure of 152/109. E. M. told Respondent that he had a history of use of tobacco, alcohol, and cocaine, but that he had "quit" using all of them. Respondent wrote in the chart that E. M. stated that he "feels he will leave [the jail] in 5 days." Respondent noted that lab work and other tests would be ordered if E. M. was not released and scheduled another chart review for June 30. In the meantime, Respondent ordered that E. M. could self-administer his medications.

On June 24 Respondent removed a duplicate order for potassium from E. M.'s medication orders.

9. A chart note states that, on June 27 in the early morning hours, E. M. was moved to sickbay after complaining of flank pain, but was transported to attend the morning court session after being provided analgesia. More details regarding the June 27 events are found in other chart notes.

A "late note" by nurse Nimfa Punzalan made on June 28 at 3:22 a.m. charted her visit to E. M.'s cell during a "man-down" incident[4] on June 27 at 1:20 a.m. At that time, she found E. M. "lying face down with a small amount of emesis." According to his cellmates, he had been walking, then fell to the floor complaining to them of "kidney pain." She found him "easily arousable" and "breathing easy." He reported to her that he had been experiencing pain in his chest for two days and that he was seen by medical staff, but "only given an ice pack." (There is no chart note describing such a clinic visit.) Punzalan also charted that E. M. told her that he had a heart problem and that he needed to be seen at San Francisco General Hospital or by his own doctor because he needed a heart transplant. She also wrote that she was "unable to verify" his history "because the computer was down" and that "he's not even on the HI risk board." E. M. was placed in sickbay "until computer resumes" and Punzalan wrote that he "never complained anymore at 0600." She advised the charge nurse of the incident.

10. On the morning of June 27, Respondent was at the jail at 6:00 a.m. in connection with his position as a negotiator for a new labor contract. A nurse approached him and said that E. M. did not want to go to court because of back pain. Respondent observed E. M. standing next to a deputy appearing calm and Respondent believed that

[4] "Man down" is called when deputies want the assistance of a nurse for any reason.

E. M. wanted to go to court. He therefore ordered two tablets[5] of Tylenol with codeine without performing a physical assessment.[6]

Respondent was not aware of the 1:20 a.m. "man-down" incident when he ordered the Tylenol. He was informed later, and at 8:30 a.m. he charted that E. M. had been moved to sickbay during the night shift "due to flank pain, went to court this AM after analgesia provided, will see [patient] tomorrow." He also wrote "Priority Two Flank pain 6/28/05" and "if [patient] still in jail order labs EKG and CXR 6/30/05." "Priority Two" means a patient is called out during standard medical call.

11. On June 28 at 9:50 a.m. nurse Liberty Forteza responded to a "man down" call from a courtroom. At 10:25 a.m. she entered a chart note regarding the incident. When Forteza arrived at the courtroom, she found E. M. laying on his right side and clutching his left chest. His eyes were closed and he responded verbally to questions. E. M. complained of chest pain, kidney pain, and that his head hurt, and "demanded to go to [the] hospital." He was able to "easily" sit in a chair and was transferred to a wheelchair. He was wheeled back to the jail and placed in the clinic.

Respondent was on duty at the clinic and had been seeing patients when someone told him that E. M. had been brought there from court. Respondent walked out into the hall and saw E. M. sleeping on a gurney. His mouth was open and he was snoring. E. M. did not respond when Respondent called his name, so Respondent continued to see patients. At some point, a charge nurse told Respondent that there had been some kind of disturbance in court and Respondent planned to ask E. M. what had happened. Respondent was not aware that E. M. had been brought to the clinic in a wheelchair. Later, a nurse told Respondent that E. M. was going back to his cell. Respondent observed E. M. "walking back towards the main line and he waved me off as he was walking." Respondent asked E. M. if he was taking his medications and he said "no." Respondent told him that "we will have to take them from you" and E. M. said "OK." Respondent also heard E. M. say "I just wasn't feeling well," or something similar. Respondent was left with the impression that E. M. no longer wished to be seen in the clinic. Respondent did not enter notes in the chart about this contact with E. M.

12. Respondent later ordered and charted that E. M.'s medications be confiscated and given to him during "pill call." On June 29, a subsequent note states that nursing staff discovered that E. M. had taken all of the medications out of their individual packets and they were "in one large mass of pills" in his cell. Respondent realized at that time that all of the items on E. M.'s "problem list" had not been dealt with. He added hypertension and congestive heart failure to the list and designated him as a high-risk patient. He also ordered the following tests: an EKG on June 30, a chest x-ray be taken on July 2, a cholesterol panel

[5] Although Respondent testified that he ordered two tablets, the Proposed Decision stated that "a tablet" was ordered. (RT163:11-19.)

[6] Acetaminophen with Codeine No. 3 is a Schedule III narcotic, which at the time was in the most dangerous drug category that a nurse practitioner could prescribe. (RT 56:11-13)

with a draw date of July 4, and a blood test to evaluate renal function, liver function, and complete blood count for July 5.

13. On June 30 at about 12:10 p.m.[7] Respondent saw E. M. in the clinic. Staff had brought E. M. to sickbay the night before because he was complaining of leg pain. E. M. stood at a counter with his hands pressed on it and appeared to be supporting his weight. He told Respondent that "whenever I lay around a lot my legs hurt." Respondent observed that he was "otherwise comfortable looking" and did not appear in acute distress. Respondent palpated E. M.'s legs and checked his pulse. He did not observe swelling or redness and found his legs and ankles to be normal. His blood pressure was in the low normal range (107/70) and his pulse was 75. E. M. then got up and said "it doesn't matter – I am bailing out tonight." Respondent asked him about the flank pain and E. M. said that he did not "have any of that now."

Respondent's chart notes of the June 30 visit include the following statements. "[Patient] has received his meds for past 2 days and BP has responded." "General appearance other has mobility limitations noted when coming into clinic [patient] walks with assist by holding furniture, when leaving clinic he walks with steady gait without hold furniture." "Assessment leg pain but consider malingering." "If [patient] still in jail order labs EKG and CXR." "[Patient] reports he has bailed out and is only awaiting release . . . [Patient] currently also denies any flank or back pain, if he stays in jail then will FU with labs, EKG and CXR . . . as was the plan." Respondent ordered Tylenol with codeine as needed.

14. E. M. died on July 1 between approximately 12:30 and 4:00 a.m. At approximately 11:45 p.m. the night before, three nurses responded to a "man down" call and found E. M. lying face down on a mattress in his cell. He told them that he was "stressed out" and denied chest pain or shortness of breath. A short time later, deputies placed E. M. in a "safety cell," where inmates are to be checked every 15 minutes. A deputy noticed that he was "not responding" at about 3:25 a.m.

15. The Medical Examiner found that E. M.'s cause of death was acute cocaine intoxication. Other "significant conditions contributing to his death" were listed as: acute pyelonephritis,[8] bronchopneumonia, and hypertensive cardiovascular disease.

Reviews of medical care given E. M.

16. Jackie Clark was the Clinical Director, City of San Francisco, Jail Health Services (JHS), at the time of these events. She was in charge of the nursing staff. Clark told an investigator that she feels that Respondent "took appropriate action while caring for E. M. during his time in jail." Her opinion was based upon her review of the nursing notes

[7] The Proposed Decision stated that the clinic appointment took place at 12:10 a.m., but the records appear to reflect that the appointment took place at 12:10 p.m.

[8] A kidney infection.

and E. M.'s medical record. She did, however, recommend that two of the nurses who responded to E. M.'s cell the morning that he died be subject to employee discipline. Her recommendation was based in part on the failure to advocate for E. M., that is, for failing to take steps to overrule the deputies and have him taken to sickbay instead of a safety cell.

17. Joseph Goldenson, M.D., has been the Director/Medical Director of JHS since 1993. The physicians, physician assistants, and nurse practitioners report to Dr. Goldenson. He has been Respondent's supervisor for over ten years. Dr. Goldenson wrote a letter in support of Respondent and testified at hearing.

Following the death of E. M., JHS supervisory personnel conducted a mortality review of the care he received while incarcerated. The review included the care provided E. M. by Respondent. In summary, it was found that the overall care that Respondent provided to E. M. was appropriate and did not contribute to the cause of death. Dr. Goldenson did believe that the care Respondent rendered E. M. and his documentation could have been better in some respects and he talked to Respondent about this. Specifically, Dr. Goldenson advised Respondent that he should have examined E. M. on June 28 when he was in the clinic and that he should have charted his encounter with E. M. that day. This is the only time Dr. Goldenson has counseled Respondent.

Expert opinion evidence

18. Michele D. Lobitz is a board-certified nurse practitioner. She has been a registered nurse for 18 years and for the past 10 years has worked as a nurse practitioner in a family practice setting. She supervises two registered nurses and four medical assistants. Lobitz was retained by Complainant to assess whether Respondent's care of E. M. was within the standard of care. She authored a written report dated May 19, 2007, and a supplemental report dated November 27, 2007. She also testified at hearing.

19. Lobitz began her analysis by reviewing documents provided to her by Complainant, including a newspaper article concerning the death of E. M., the Medical Examiner's autopsy report, the investigator's report of interview of Respondent, and chart notes from June 24 through June 30. She initially did not see the note describing Respondent's examination of E. M. on June 23.

Her report stated that the "ordinarily responsible prudent NP, evaluates the patient's condition and formulates a plan of care to determine a diagnosis and treat a health condition." Lobitz concluded in her written report that Respondent was negligent in that he failed to assess E. M. on June 28; to completely assess E. M. on June 30; and "to order diagnostic tests promptly to identify the cause of E. M.'s repeated 'man down' episodes." The report states that a thorough assessment to determine the cause of E. M.'s symptoms would not have prevented his death from cocaine intoxication, but would have identified conditions contributing to his death. She concludes that these failures "contributed to the

development of life threatening infections including: pyelonephritis and pneumonia. These conditions contributed to E. M.'s demise."[9]

20. After the report was issued, Complainant's counsel contacted Lobitz and asked her whether she "intended [her] original statement" and also whether she found gross negligence or incompetence in the care provided E. M. by Respondent. Lobitz told Counsel that she "would look through the standards of competent practice and get back to her." Lobitz then issued a supplemental report opining that the three failures she found constituted incompetence under "Business and Professions Code section 2761" and "California Code of Regulations 1443.5 (2)."

21. Lobitz has no experience practicing in correctional facilities or any special education or training in delivering health care in such a setting. At some time subsequent to her initial written report and prior to testifying, Lobitz reviewed two documents to which she referred. Complainant submitted the documents in evidence. They are: "Scope and Standards of Nursing Practice in Correctional Facilities," a publication of The American Nursing Association (ANA), printed from the ANA website on April 23, 2008, and "Clients in Correctional Facilities," a chapter from a textbook. Consistent with theses exhibits, Lobitz testified that the standard of care is the same in the prison setting as it is in the community.[10] She noted that the Supreme Court has ruled that a nurse's responsibility is increased because incarcerated persons are completely dependent on the prison system for care, and that the American Correctional Health Services Association states that the health professional should evaluate the patient in each and every health encounter. (RT 48:4-49:17) She still opined that there is not a different standard between nursing practiced in a prison from that practiced in another healthcare setting, (RT 45:20-24) and that the basic purpose of the nurse is to advocate for and assess the patient, and her testimony did not differ substantially from the opinion contained in her report. (RT 74:16-21)

22. Prior to testifying, Lobitz was provided with the chart notes that describe the examination of E. M. by Respondent on June 23. Lobitz's initial opinion was based in part on her understanding that Respondent had ordered a Tylenol with codeine, without having performed a physical examination. After receiving information to the contrary, although she had no criticism of the notes of the exam and the actions Respondent took, she did not change her opinion. Lobitz testified that diagnoses are derived from assessment data, (RT 68:6-7) and that it constituted incompetence for Respondent to fail to formulate an appropriate plan of care. (RT 67:10-14)

23. Lobitz testified that there was no assessment conducted at the time of and prior to administering the medication, and that competent practice includes conducting an

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[9] The Proposed Decision incorrectly states that Lobitz's report did not mention the acute cocaine intoxication that caused E. M.'s death.

[10] The Proposed Decision indicated that Lobitz testified to the standard of care being the same as in the community "despite" the materials reviewed and referenced, and entered as exhibits. A review of the record, however, seems to show that the exhibits did not establish a different standard.

assessment to evaluate the need and the appropriateness of the medication. (RT 70:1-5.) Specifically, she further testified that Respondent failed to follow through with his plan to perform an assessment of the patient on June 28th. (RT 74:6-12.)

She also testified that although lab tests were ordered, some were four or five days after the patient presented with the complaint. (RT 72:8-11) She opined that nursing care and the formulation of the plan and diagnostic tests must be done in a timely manner. (RT 72:9-11) Accordingly, she testified that certain assessments should have been performed on June 30th. (RT 70:6-72:7.) Specifically, Respondent noted that E. M. had been placed in sick bay for leg pain, but he did not perform a musculoskeletal assessment. In the days prior to June 30th, the patient had complained of chest pain and had an extremely elevated blood pressure, but no assessments were performed to determine if the pain was a symptom of a heart attack or other cardiovascular disease, or pneumonia. The patient had also complained about flank pain or kidney pain, but no assessments were performed to look for a kidney infection. Failure to order tests in a timely manner contributed to the failure to identify conditions that were contributing factors to E. M.'s death. (RT 77:1-3.) If those tests had been done and had all come back normal, then a clinician might be able to entertain a diagnosis of malingering. (RT 76:5-9.)

24. Dr. Goldenson also testified in the capacity of an expert in correctional medicine.[11] He is extremely well qualified.[12] In addition to his position with JHS, Dr. Goldenson is an expert in the delivery of health care to the incarcerated. He has worked in correctional medicine for over 20 years and has been appointed as a medical expert by the federal court in three cases concerning the provision of health care to prisoners. Dr. Goldenson has also conducted evaluations of correctional health care services in various locations including Los Angeles, Miami, and Dallas. The evaluations include talking to patients and staff and reviewing medical records to determine if appropriate medical care was provided. Dr. Goldenson is an associate editor of Clinical Practice in Correctional Medicine and deputy editor of Public Health Behind Bars: from Prisons to Community. He testified that health care in correctional institutions are structured very differently from community settings in that they are very nurse-driven. (RT 101:23-25.)

25. In reviewing the care given E. M. by Respondent, Dr. Goldenson first reviewed the medical records. He noted that when E. M. was admitted, he gave the nurses a history of his medical problems. This included that he was "supposed to get a heart transplant" and that he had been hospitalized for a stroke. It was later found that there was no heart transplant planned and that he had not been hospitalized for a stroke. Dr. Goldenson describes himself as a patient advocate, but notes that one of the tasks of jail medical personnel is to sort out those who are exaggerating from those who truly need medical

[11] Dr. Goldenson was also a percipient witness in that, as his supervisor, he reviewed Respondent's care of E. M. in this case, and was called by Complainant to testify to that. Although he apparently was not identified as Respondent's expert pre-hearing, no motion to exclude his expert testimony was made.

[12] The Proposed Decision found Dr. Goldenson to be a "persuasive witness."

attention. Nurses necessarily monitor and evaluate the patients while they are waiting to be seen. It is in this light that the "consider malingering" note should be taken.

Dr. Goldenson pointed out that the Accusation fails to include the complete history and physical examination of E. M. by Respondent on June 23. The only acute problem at the time was elevated blood pressure. In addition, E. M. advised Respondent that he would be leaving jail within five days. Therefore, the decision to postpone ordering tests was "appropriate and is consistent with the generally accepted standard of care in jails, especially since E. M. had always been released after a brief stay during his prior incarcerations." However, he testified that only about 15% of the inmates know when they will be released because they have been sentenced to a certain amount of time in jail; the rest do not know when they will be released. (RT 107:10-17.)

The fact that Respondent examined E. M. on June 23 also affects the claim that Respondent's order of a Tylenol with codeine on June 27 constituted incompetence. Dr. Goldenson wrote in a letter sent to the Board:

> Since E. M. did not appear to be in significant distress and was anxious to go to court, the charge nurse asked [Respondent] for a verbal order for pain medication, at which point [Respondent] ordered the Tylenol with Codeine. Ordering a short course of pain medication, in this case a single dose, pending a re-evaluation, is something that was done out of concern for the patient, would be a common practice in any outpatient setting, and, most certainly, does not rise to the level of incompetence or gross negligence.

Dr. Goldenson, however, did not testify to what is the standard for conducting an assessment prior to administering pain medication to properly evaluate the need and appropriateness of the medication administered. He did not contradict Lobitz's testimony that competent practice of a nurse practitioner includes conducting an assessment prior to the administration of such pain medications, but merely opined that an assessment four days prior to such an administration was not incompetent. In addition, he characterized E. M. as "anxious" to go to court on that day, but there is no evidence to support that. The nurse accompanying E. M. indicated that he said he did not want to go to court, and Respondent simply testified that he "believed" E. M. wanted to go to court. Moreover, Dr. Goldenson's opinion is that the single dose of medication did not rise to the level of incompetence or gross negligence where it was pending a re-evaluation. Such a re-evaluation was not completed, and as found in 17 and 26, resulted in his counseling Respondent. (RT 122:9-123:7.)

Dr. Goldenson found nothing amiss in Respondent's care of E. M. on June 30, when he again ordered Tylenol with codeine.

> There was no indication to perform a respiratory assessment at that time as E. M. was not complaining of any respiratory problems, his vital signs were normal and there was no indication to perform a musculoskeletal assessment or an assessment for CVA tenderness as he stated he no longer had flank pain.

26. As stated above in Finding 17, Dr. Goldenson is of the opinion that Respondent's treatment of E. M. on June 28 (after E. M. complained in the courtroom and was brought back to the jail) could have been better and that he counseled Respondent to that effect. He wrote:

> [Respondent] subsequently interviewed E. M. but did not perform a physical examination . . . I agree that [Respondent] should have performed a physical examination at that time. In addition he did not document his encounter with E. M. However, as above, the failure to perform a physical examination and the lack of documentation during one visit does not rise to the level of incompetence or gross negligence.

Dr. Goldenson, however, did not testify as to what is the appropriate standard for performing a physical examination, or documenting a visit, and did not controvert Lobitz's testimony that timely assessments are required and Respondent should have followed through with his plan to perform an assessment on that date.

27. Dr. Goldenson noted the Medical Examiner's findings and opined that:

> While in jail, E. M.'s hypertension was appropriately managed and well-controlled once he began taking the medication ordered by [Respondent]. When E. M. saw [Respondent] on Ju[ne] 30, he was not complaining of any symptoms that would have indicated he had pneumonia or a urinary tract infection. Even if these "mild"[13] infections had been diagnosed and treatment initiated, E. M.'s death from acute cocaine intoxication would [not] have been prevented.

28. Milton N. Estes, M. D., is board certified in family practice and a certified specialist in HIV medicine. He is currently the Medical Director of the HIV services in the San Francisco County Jails and Assistant Medical Director of JHS. He has known Respondent for many years as a colleague and sometimes as his supervisor. Dr. Estes wrote a letter in support of Respondent and testified at hearing.

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[13] The medical examiner found evidence of "acute bacterial bronchopneumonia, bilateral" and "acute pyelonephritis, bilateral." It is unclear whether Dr. Goldenson's conclusion that E. M. suffered from "mild" infections is inconsistent with the medical examiner's report.

In general, Dr. Estes knows Respondent "to be a conscientious and excellent clinician, and ha[s] never had cause to doubt his competence." Dr. Estes reviewed the medical records of the care received by E. M. in mid-2005. His opinion was consistent with Dr. Goldenson's – that the care provided by Respondent was appropriate and met the standard of care.

29. In addition, Dr. Estes described the challenge in the correctional setting of distinguishing "true medical illness from complaints that are the result of attention seeking or personality disorder." Dr. Estes noted that Respondent conducted a complete examination of E. M. on June 23 and saw him in the following few days and that the record contains many complaints by E. M. of various types of "transient" pain that were not substantiated by examinations. Dr. Estes's view of the autopsy results beyond the finding of cocaine intoxication is that they were incidental. He opined that, if E. M. "had not died, no one would have suspected lung or kidney disease."

Dr. Estes initially testified that it was the job of a nurse -- not a clinician's -- to assess a patient's complaint. He then testified, however, that if a patient makes a complaint to a clinician such as a nurse practitioner, then the standard of practice is for the nurse practitioner to assess the patient and try to make a determination as to what is causing the complaint. (RT 156:22-157:7.)

30. Complainant's expert Lobitz's opinion that Respondent's care of E. M. was not only negligent and incompetent, but that it "contributed to his demise," is persuasive because she testified as to the standard of practice for a nurse practitioner. Although Lobitz has no background in correctional medicine, she testified that the standard of practice does not differ depending upon the healthcare setting; that opinion was uncontroverted.

Other matters

31. Dr. Goldenson wrote the following regarding his opinion in general of the care provided by Respondent at JHS:

> He is an accomplished nurse practitioner and has consistently received outstanding performance evaluations for providing excellent medical care, including acute, chronic and emergency care, to his patients. His clinical skills are highly developed and he appropriately seeks clinical consultation with one of our physicians when that is indicated. He has a reputation among staff and inmates as a highly experience nurse practitioner who provides high quality care.

32. Dr. Goldenson completed performance evaluations of Respondent on December 2, 2005, December 7, 2006, and June 15, 2007. He assessed his performance as "outstanding" on each evaluation.

Costs

33. Deputy Attorney General Kim M. Settles submitted a declaration certifying that the Department of Justice has billed or will bill the Board $4,540.50 for work performed in the investigation and prosecution of this matter. Complainant submitted a certification of costs certifying that the Board has incurred the following additional costs of investigation and prosecution: Division of Investigation $4,194 and Expert $281.25. The total costs are therefore $9,015.75.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 1 through 30, cause for disciplinary action exists pursuant to Business and Professions Code section 2761, subdivision (a)(1), providing that a nurse can be disciplined for unprofessional conduct that includes, but is not limited to, "incompetence, or gross negligence in carrying out usual certified or licensed nursing functions." California Code of Regulations, title 16, section 1443, defines incompetence as "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse." Respondent failed to formulate a plan of care for patient E. M., failed to follow through with his plan to perform an evaluation on June 28th, and failed to perform an assessment on June 30th. He failed to timely order diagnostic tests to determine the cause of E. M.'s complaints and assess and treat his medical conditions.

2. Respondent acknowledged that he would have accelerated the testing he had ordered had he known that E. M. was not about to be released, among other factors. The evidence was uncontroverted, however, that only a small percentage of jail inmates know for certain when they will be released. It was shown by clear and convincing evidence that his care of E. M. was incompetent.

3. Although Complainant has proven that Respondent's care of E.M. was incompetent, there was also competent evidence of Respondent's skill and reputation otherwise as a nurse practitioner. Moreover, E. M., unfortunately, died from cocaine intoxication, and not directly from an undiagnosed medical condition that may have been detected from timely diagnostic tests. Accordingly, the public will not be further served or protected by revoking Respondent's license or placing any terms and conditions upon his ability to practice as a nurse practitioner. A public reprimand is sufficient to further the Board's priority to protect the public in this instance.

4. Business and Professions Code section 125.3(a) provides in part that the board:

> may request an administrative law judge to direct a licentiate found to have committed a violation or violations of the

licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

Business and Professions Code section 125.3(d) provides in part:

The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award.

Because there was no finding of the reasonableness of the costs, no costs can be awarded.

ORDER

Respondent's Motion to Vacate Order Granting Complainant's Petition for Reconsideration is DENIED.

Complainant's Petition for Reconsideration having previously been granted, the Board's decision of September 24, 2008, is hereby VACATED.

The Board hereby issues a public REPROVAL to Respondent John Charles Poh, Jr., RN, Registered Nurse License No. 451774, Nurse Practitioner Certificate No. 8355, and Nurse Practitioner Furnishing Certificate No. 8355 pursuant to Business & Professions Code section 495.

DATED: June 12, 2009

Susanne J. Phillips, MSN, RN, FNP-BC

SUSANNE J. PHILLIPS, MSN, RN, FNP-BC
President,
Board of Registered Nursing

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOHN CHARLES POH, JR.** **2630 22nd Avenue** **San Francisco, California 94116** **Registered Nurse License No. 451774** **Nurse Practitioner License No. 8355** **Nurse Practitioner Furnishing License No. 8355** Respondent.	Case No. 2008-217 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1990, the Board of Registered Nursing issued Registered Nurse License Number 451774 to JOHN CHARLES POH, JR. (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2007, unless renewed.

3. On or about June 26, 1996, the Board of Registered Nursing issued Nurse Practitioner License Number 8355 to JOHN CHARLES POH. The Nurse Practitioner License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2007, unless renewed.

4. On or about January 29, 1998, the Board of Registered Nursing issued Nurse Practitioner Furnishing License Number 8355 to JOHN CHARLES POH. The Nurse Practitioner Furnishing License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2007, unless renewed.

JURISDICTION

5. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

6. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Title 16, California Code of Regulations, section 1443 defines incompetence as "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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9. Title 16, California Code of Regulations, section 1443.5 defines standards of competent performance as follows:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures."

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. "Tylenol with codeine #3", is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(2) and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

12. On or about June 24 through July 1, 2005, while employed as a nurse practitioner at the San Francisco County Jail, in San Francisco, California, respondent provided care to patient/inmate E.M.[1] Respondent provided said nursing care in an incompetent and/or grossly negligent manner by failing to formulate an appropriate care plan, which included appropriate and timely assessments and orders for diagnostic testing. The circumstances are as follows:

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1. Patient initials are used to protect the patient's privacy. full names will be released to respondent in discovery.

a. E.M. presented to San Francisco County Jail, on June 21, 2005, as a patient/inmate with a medical history of high blood pressure and congestive heart failure. On June 24, 2005, respondent performed a chart review and adjusted E.M.'s medication. On June 27, 2005, at approximately 1:20 a.m., Nimfa Punzalan, RN, responded to a "man down" code and charted[2] that she found E.M. lying face down with a small amount of emesis. According to cell mates, E.M. was walking and fell to the floor, complaining of "kidney pain". Punzalan charted that E.M. advised her that he had a heart problem and needed to be seen by his own doctor or go to San Francisco General Hospital. On June 27, 2005, at approximately 7:15 a.m., Romy Adiano, Clinical Nurse, administered 1 tablet of Tylenol with Codeine #3, to E.M., upon respondent's verbal order. Respondent did not perform a physical examination of E.M. prior to making said order. That same day, at 8:30 a.m., respondent performed a second chart review and noted that E.M. "moved to sick bay last NOC (night) due to flank pain, went to court this AM after analgesia provided, will seen pt tomorrow", "Priority Two Flank pain 6/28/05", "if pt still in jail order labs EKG and CXR 6/30/05".

b. On June 28, 2005, Liberty Forteza, RN, responded to a "man down" code and found E.M. lying on his right side, clutching his chest. Forteza charted that E.M. complained of chest and kidney pain, headache, burning sensation, and high blood pressure. E.M. demanded to go to the hospital and was taken to the clinic for observation. Respondent approached E.M., while he was lying on a bench or gurney in the hallway outside the clinic, on June 28, 2005, and E.M. informed respondent, "I just don't feel well." After E.M. advised respondent that he was not taking his medication, respondent ordered that E.M.'s medications be distributed during "pill call", instead of allowing E.M. to self-administer his medication. On said date, respondent failed to perform an

2. Punzalan charted a late entry for the "man down" call on June 28, 2005, at 3:22 a.m.

assessment/examination of E.M. On June 29, 2005, at approximately 8:41 a.m., respondent performed a third chart review and ordered supervised medication administration for E.M. Respondent also ordered an EKG for June 30, 2005; chest x-ray on July 2, 2005; and blood tests on July 4, 2005, which included fasting lipids, RFT (renal function), CRP (C reactive protein), LFT (liver function), and CBC (complete blood count). Respondent noted Congestive Heart Failure in E.M.'s chart. On June 30, 2005, at approximately 12:10 a.m., respondent examined E.M. in the clinic after he had been placed there during the night shift for leg pain and charted that E.M. informed him that he had this pain in the past. Respondent ordered Tylenol #3 with Codeine without performing a complete assessment of E.M. in that respondent failed to perform a respiratory assessment, musculoskeletal assessment, or assessment for costovertebral angle (CVA) tenderness (a maneuver to check for pain over the kidney which might indicate infection). Respondent added a note to E.M.'s chart "leg pain but consider malingering." Respondent noted an addendum that E.M. currently denies flank or back pain and reported that he had "bailed out" and is "only awaiting release". On or about June 30, 2005, at approximately 11:45 p.m., Punzalan, Evangeline Anacleto, RN, and Mike Fowler, LVN, responded to a "man down" code and found E.M. lying face down on a mattress on the floor of his cell. E.M. stated that he was "stressed out" and denied chest pain or shortness of breath. The nurses left E.M. in his cell and returned to the clinic to access and review E.M.'s medical records. Approximately twenty minutes later, a sheriff's deputy notified Punzalan and Anacleto that E.M. had been placed in a "safety cell", where inmates are checked by deputies every fifteen minutes. At approximately 4:08 a.m. on July 1, 2005, E.M. was pronounced dead in his cell. The cause of death was listed as "acute cocaine intoxication", with acute pyelonephritis, bronchopneumonia, and hypertensive cardiovascular disease listed as other significant conditions contributing to death.

13. Respondent is subject to discipline under Code section 2761(a)(1) (incompetence) in that respondent failed to formulate a plan of care which provided for E.M.'s safety, as follows:

a. Failed to follow through on his plans to assess E.M. on June 28, 2005, instead delaying any assessment until June 30, 2005. As a result thereof, respondent ordered pain medication for E.M. on June 27, 2005, and June 30, 2005, without performing a thorough examination and assessment.

b. Failed to conduct a complete assessment of E.M. on June 30, 2005, in that, on said date, respondent did not perform a respiratory assessment, musculoskeletal assessment, or assessment for costovertebral angle (CVA) tenderness (a maneuver to check for pain over the kidney which might indicate infection), although E.M. had complained of flank or kidney pain. A complete assessment of E.M. may have identified serious health conditions which contributed to his death, including pyelonephritis and pneumonia.

c. Failed to promptly order diagnostic tests to identify and determine the cause of E.M.'s repeated "man down" episodes, thereby delaying the diagnosis of life-threatening conditions which may have contributed to E.M.'s death.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 451774, issued to JOHN CHARLES POH, JR.

2. Revoking or suspending Nurse Practitioner License Number 8355, issued to JOHN CHARLES POH, JR.

3. Revoking or suspending Nurse Practitioner Furnishing License Number 8355, issued to JOHN CHARLES POH, JR.

4. Ordering JOHN CHARLES POH, JR. to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to

Business and Professions Code section 125.3;

5. Taking such other and further action as deemed necessary and proper.

DATED: 1/18/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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